EXHIBIT 5

PACIFIC GROWTH EQUITIES

REQUIRED DISCLOSURES
PLEASE SEE APPENDIX A FOR REQUIRED CERTIFICATIONS AND DISCLOSURES

equity research

February 26, 2007

GPC Biotech AG

SPARC data presented at ASCO Prostate Symposium

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GPCB:Nasdaq
Buy

Price	$31.86
Price Range (52 weeks)	$13.15-$33.04
Shares Outstanding (millions)	33.3
Market Capitalization (millions)	$1,060.9
Estimated cash at Q1:07 (millions)	€107.9
Estimated FY:07 Burn (millions)	€60.3

Year	Revenue (millions)	Operating Margin	Operating EPS	P/E Ratio
12/05A	€9.3	NM	€(2.08)	NM
12/06E	€24.1	NM	€(2.03)	NM
12/07E	€48.2	NM	€(1.77)	NM

FY:06 Quarterly Estimates	Q1A	Q2A	Q3A	Q4E
Revenue	€5.4	€5.6	€6.6	€6.5
EPS	€ (0.41)	€ (0.46)	€ (0.56)	€ (0.60)

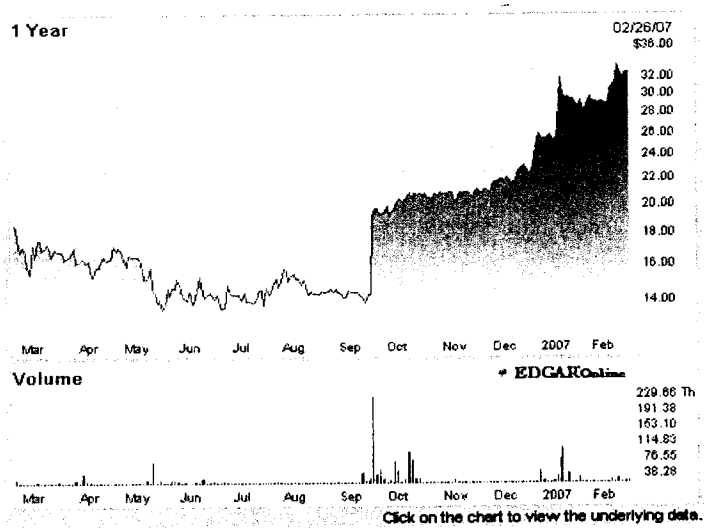

Chart Source: Nasdaq.com

SUMMARY

- More detailed data from the SPARC study was presented at ASCO Prostate Cancer Symposium (Feb 22-24, Orlando, FL) in an oral session by Dr. Dan Petrylak from Columbia University.
- We noted that the level of excitement towards satraplatin was high from the prostate cancer community, and we discuss what the experts' thoughts are with regard to satraplatin's approvability and potential use.
- Next events: notification from the FDA on whether NDA is accepted for filing (mid April); potential ODAC panel (June 1); presentations at ASCO (June 1-6, Chicago, IL).

CONCLUSION

We believe that satraplatin's use in prostate cancer would not be limited to 2nd line HRPC if potentially approved. Based on our checks with thought leaders, satraplatin use could be expanded to front line HRPC and other settings of prostate cancer, as discussed herein. In addition, we believe the satraplatin franchise will be further expanded by randomized Phase II studies or pivotal studies in settings other than prostate cancer where satraplatin would provide advantages in efficacy, tolerability and/or convenience. We expect strong data flow from the 10 earlier studies on satraplatin during FY:07. We continue to believe satraplatin is a substantial asset with over what we estimate to be $1 billion in sales potential. We reiterate our ***Buy*** rating ahead of upcoming analysts including potential approval of satraplatin in the U.S.

- **More detailed data from the SPARC study was presented at ASCO Prostate Cancer Symposium**

Dr. Dan Petrylak presented more detailed data from the SPARC study at the ASCO Prostate Cancer Symposium (Feb 22-24, Orlando, FL) in an oral session. Dr. Petrylak is a thought leader and leading specialist and practitioner in the advanced prostate cancer field. He is one of the 2 North American principle investigators who co-authored the SPARC study protocol. He was intimately involved with the SPARC study from conception, design and planning all the way through execution. We review the data below.

Baseline patient characteristics

The satraplatin arm and the placebo arm were well balanced with regard to baseline patient characteristics at study entry. The median age at study entry was 68-70 years. Approximately 90% of patients in the study had performance status (PS) of 0-1, and 10% had PS of 2. Approximately 35% of patients had pain score of 0, and 65% had pain score of 1-5. 62% of patients progressed after front line chemotherapy due to tumor progression, and 38% of patients progressed based on PSA progression only. Approximately 51% of patients received Taxotere as front line chemotherapy; among the rest, 3% received Taxol and 20% received mitoxantrone. Approximately 27-30% of patients were taking bisphosphonate at study entry.

Primary endpoint

On the primary endpoint progression-free survival (PFS), the data presented at this ASCO Prostate Symposium is slightly different from the topline data released in September, 06. This is mainly due to 2 reasons: 1) the present analysis included more PFS events, 802 events as opposed to approximately 770 events in the Sept, 06 analysis; 2) the present analysis adjusted for 3 pre-specified stratification factors, namely performance status, presence and intensity of pain, and type of progression after front line chemotherapy; the Sept 06 analysis was adjusted for 9 factors, including the 3 used in the present analysis. We present the data separately in Tables I and II below to demonstrate the differences. We note that such slight differences do not affect the compelling overall results achieved on the primary endpoint.

Table I. SPARC topline data points as reported in September, 06

	Satraplatin	Control	Comments
Progression-free survival (PFS), primary endpoint	Approximately 770 events analyzed; 40% reduction in risk of disease progression hazard ration = 0.6 (95% CI, 0.5-0.7) p<0.00001		
PFS at median (50th percentile)	11 weeks	9.7 weeks	13% improvement
PFS at 75th percentile	36 weeks	19 weeks	89% improvement
% patients not progressed at 6 months	30%	17%	--
% patients not progressed at 12 months	16%	7%	--

Source: GPCB, Pacific Growth Equities, LLC.

Table II. SPARC data as reported at this ASCO Prostate Cancer Symposium

	Satraplatin	Control	Comments
Progression-free survival (PFS), primary endpoint	802 events analyzed; 33% reduction in risk of disease progression hazard ration = 0.67 (95% CI, 0.57-0.77) p=0.0000003		
PFS at median (50th percentile)	11.1 weeks	9.7 weeks	14% improvement
PFS at 75th percentile	34.6 weeks	19.1 weeks	81% improvement
% patients not progressed at 6 months	30%	17%	--
% patients not progressed at 12 months	16%	7%	--

Source: Petrylak et al., 2007 ASCO Prostate Cancer Symposium, Abstract #146; Pacific Growth Equities, LLC.

As expected, the Kaplan-Meier PFS curves started to separate early but were close to each other (13% improvement at median) and the differences between the curves kept expanding (81% improvement at 75th percentile).

Among the PFS events, 36% were based on radiological progression (tumor growth), and 37% were based on pain progression.

The Taxotere-treated population

As Taxotere was not yet approved for front line HRPC at the time SPARC started recruiting patients and in some study countries Taxotere was not available, about 51% of the SPARC study population was treated with Taxotere as the frontline therapy prior to satraplatin treatment. It is therefore important to discern whether there are any differences in satraplatin efficacy based on type of prior chemotherapy received. With the 51% patients who received Taxotere as front line therapy, the hazard ration was 0.67 with a p value of 0.0006, essentially the same results as the overall study. This shows that the satraplatin treatment effects are not affected based on prior chemotherapy types. This was also substantiated from pre-clinical studies that satraplatin does not have cross resistance with the front line chemotherapy agents.

Safety and tolerability

Major toxicity of satraplatin was hematological or myelosuppression, as expected for the platinum class of compounds. Grade 3&4 leukopenia (13.7% vs. 0.6%), neutropenia (21.1% vs. 0.6%), thrombocytopenia (21.1% vs. 1.3%) and anemia (9.4% vs. 3.2%) were noted. We note that such myelosuppression caused by satraplatin is milder compared to other platinum compounds, and is reversible and non-cumulative.

Major satraplatin-related non-hematological toxicities at Grade 3&4 include vomiting (1.6% vs. 0), diarrhea (2.1% vs. 0), and infectious episodes (4% vs. 1%). Notably, no differences were detected among satraplatin arm vs. the placebo arm with regard to kidney function impairment or neuropathy; this compares favorably with traditional platinum compounds.

Median cycles received by the satraplatin arm and the placebo arm were 4 (range 1-28) and 2 (range 1-16), respectively. 40% satraplatin-treated patients received 5 cycles or more of treatment as compared to 20% of the placebo arm; 20% of satraplatin-treated patients received 7 cycles or more as compared to 10% of patients from the placebo arm.

The dropout rate for the entire study was less than 10%, which compares very favorably with other oncology studies, especially given the fact that the patient population had a median age of 68-70. These data demonstrated that satraplatin was safe and well tolerated.

Secondary endpoints

Data on the secondary endpoint overall survival (OS) is expected to mature in fall, 07. The trend OS analysis at the interim conducted by the DSMB in June, 06 was included as supporting data for the NDA submitted in mid February. The time to pain progression, PSA data, as well as subgroup analyses have been submitted to a future medical conference, most likely ASCO (June 1-6, Chicago, IL).

- **Physicians' excitement around SPARC study and satraplatin's approvability**

We noted at the Symposium high level of excitement towards satraplatin from the prostate cancer community.

Quality and significance of the SPARC data

Leading experts we talked to believe that the quality of the SPARC study is high in that the data demonstrated highly statistically significant results on the primary endpoint of progress-free survival (PFS) with the most rigorous intent-to-treat analyses. They believe that the design of the PFS endpoint, being a composite of tumor and pain progression, as well as the conduct of centralized review, are rigorous and set the standard for prostate cancer trials in the future.

Meaning of the widening PFS curves

The Kaplan-Meier PFS curves started to separate early but were close to each other (13% improvement at median) and the differences between the curves keep expanding (81% improvement at 75th percentile). This means that 60% of patients in the SPARC study had some degree of benefit from satraplatin, while 25% had substantial benefit, and the widening of the PFS curves may translate into an OS benefit.

Clinical relevance of PFS

Prostate cancer specialists believe that both "live longer" as characterized by OS, and "live better" as characterized by PFS, are important when considering a drug for approval, although OS is generally considered the gold standard for cancer therapies. In the 2nd line prostate cancer setting where there is no approved or effective treatments, quality of life issues such as pain-free progression is very important to these patients and should be taken into consideration.

Approvability on "accelerated approval"

Under the SPA, data on the primary endpoint progress-free survival (PFS) is the basis for "accelerated approval". Almost all physicians we spoke to believe that given the rigor of the data on PFS, satraplatin is highly likely to be approved under this setting, and that the benefit seen with PFS is sufficient for them to adopt satraplatin in their treatment armamentarium. In addition, experts emphasize that satraplatin is effective in both Taxotere-treated and non-Taxotere-treated patients which could gain it broadest claims in the 2nd line setting.

Approvability on "final approval"

The "final approval" of satraplatin is subject to the quality of data on the secondary endpoint overall survival (OS), whose final analyses is due out in fall, 07. If the OS improvement by satraplatin is statistically significant, satraplatin should be granted full approval. If OS only shows a positive trend, supported by positive analysis on pain-free progression, the drug is still likely to be granted full approval according to experts. If there is no survival benefit and no pain benefit, doctors believe it would be a hard call.

However, we speculate that given the large magnitude of benefit shown on PFS, it will probably be unlikely that both pain-free progression and OS analyses are negative. We also note that 37% of progression events in the SPARC study were due to pain; if the pain-free progression analysis was not significantly positive, it would be unlikely for the composite PFS to have reached $p<0.00001$, in our opinion.

Mild side effect profile and convenience of dosing encourage adoption

Investigators were impressed with the mild side effect profile satraplatin demonstrated; some commented that it was hard to distinguish in their hands which patients received satraplatin and which received placebo, especially in this group of elderly patients. In addition, some experts believe that the oral route of administration of satraplatin is important for this group of elderly patients as there would be no need for infusion or traveling to the clinic for satraplatin treatments. We also note that the DSMB convened 3 times and no issues on the safety or conduct of the Study ever arose.

- **Physicians thoughts on future satraplatin use in prostate cancer**

Standard of care in 2nd line HRPC; expanding 2nd line patient population

The consensus from the prostate cancer experts we noted was that satraplatin would become standard of care in the 2nd line HRPC setting if approved. There are no agents approved for this setting at the present time, and doctors need options to treat patients progressed from front line therapies. Experts also believe that that the field realizes now that chemotherapy is effective in advanced prostate cancer, and more and more patients are being treated earlier. As a result, failures from the frontline therapies including Taxotere would also occur earlier, expanding the 2nd line population.

15-50% of elderly HRPC patients are not fit enough to receive Taxotere treatments as front line

Doctors we talked to estimate that 15-50% of elderly HRPC patients cannot tolerate Taxotere's side effects and therefore are not treated with chemotherapy. Based on satraplatin's mild side effect profile in particular lack of neuropathy as well as convenience of oral dosing, doctors believe that satraplatin will be used as front line therapy in these patients even if it is

approved for the 2nd line setting only. We also note that the EORTC study (Sternberg et al., Oncology 2005;68:2-9) provided evidence that satraplatin has single agent activity in front line HRPC.

Potential front line use in patients fit to receive Taxotere treatment
We believe that in patients fit to receive Taxotere treatment, whether satraplatin would be used in place of Taxotere in the front line will be driven by efficacy data and its better tolerability profile. We note that currently there is no direct comparison of efficacy between Taxotere and satraplatin in the front line setting.

However, Taxotere and satraplatin combination studies are currently being conducted; as the two agents may be synergistic, the combination therapy may offer superiority in efficacy to either single agent without much added toxicity. If so, we believe that the combination therapy could be established as the standard of care in the front line setting.

Combination with hormonal treatments or in adjuvant settings
Chemotherapies including Taxotere are being tested for benefits in earlier stage prostate cancer including hormone-dependent prostate cancer and in adjuvant settings. We believe satraplatin is a better candidate than Taxotere in these settings due to its better safety profile. Potential use in this setting would need to be supported by substantial efficacy and safety evidence but if successful, would greatly expand the potential market for satraplatin.

- **Our thoughts on the next steps/scenarios on satraplatin's potential approval in 2nd line HRPC**

GPCB completed the rolling submission of NDA for satraplatin in 2nd line HRPC during mid February, 07, and applied for "priority review". The NDA package included the final data on the primary PFS endpoint as well as data from the interim OS analysis. We believe the FDA could either grant the "accelerated approval" around mid August, 07, or wait until fall, 07 for the OS data release to grant the "final approval".

An ODAC panel may be called, and if so, the most likely date would be June 1, 07, the first day of ASCO (June 1-7, Chicago, IL). We note that the reason for a potential ODAC panel would not be due to quality of data, but the fact that satraplatin is a new agent for a setting for which there are no approved or effective agents.

We believe that satraplatin will be granted "accelerated approval" based on the strong efficacy data shown on the PFS endpoint. Given the large magnitude of benefit shown in the primary endpoint PFS, we are confident in the success of the final OS analysis expected in fall, 07, based on which satraplatin would be granted "final approval".

- **The SPARC Study design- a review**

Background. GPCB's lead product candidate satraplatin is an oral, 3rd generation platinum compound. The 950-patient Satraplatin and Prednisone against Refractory Cancer (SPARC) Phase III trial is ongoing in the 2nd line chemotherapy setting for hormone refractory prostate cancer (HRPC); full enrollment was achieved in December, 2005, slightly over the enrollment target of 912 patients. The interim safety and efficacy analysis passed the futility analysis in April, 2006, and positive topline PFS data was reported September, 06. GPCB has obtained a special protocol assessment (SPA) from the U.S. FDA and a similar agreement (Scientific Advice Letter) from the EMEA for the SPARC study. The U.S. rolling NDA filing for this indication was completed in mid February, 07 by GPCB, and EMEA filing is expected in H1:07 by Pharmion. Satraplatin has Fast Track designation in the U.S.; the chemistry, manufacturing and controls (CMC) section of the NDA was submitted in December, 2005, and the non-clinical section was submitted in July, 2006.

We note that there are no chemotherapeutic agents currently approved for 2nd line HRPC.

Patient population and inclusion/exclusion criteria. To be enrolled in the trial, patients must have Stage D2 metastatic prostate cancer with disease progression after one line of therapy with a chemotherapy regimen, an ECOG performance status of <=2, life expectancy of greater than 3 months, previous medical or surgical castration (hormone refractory, serum testosterone less than 50 mg/dL), and adequate bone marrow, hepatic and renal function. Key exclusion criteria include more than one previous treatment with a chemotherapy regimen, previous treatment with a platinum analog, previous

diagnosis with another malignancy, significant previous radiation or radionuclide therapy, inability to adequately absorb satraplatin after oral administration (patients with GI diseases or with major GI surgeries), a contraindication for steroid use, and brain metastases (Sternberg, BJU International, 96:990-994, 2005).

Stratification. Patients are pre-stratified by 3 categories: 1) performance status: ECOG 0-1 vs. 2; 2) average baseline present pain intensity (PPI) score: 0-1 vs. 2-5; 3) Type of progression: PSA progression vs. disease progression on prior chemotherapy.

Dosing and scheduling. 950 patients were randomized 2:1 in favor of the satraplatin arm to receive either satraplatin at 80 mg/m^2/day or placebo daily on days 1-5 on a 35-day (5-week) cycle, with both arms receiving prednisone at 5 mg twice daily for 35 days. The patients in the satraplatin arm also received the anti-emetic agent granisetron at 1mg daily, and the patients in the placebo arm received a placebo anti-emetic. Dose of satraplatin can be escalated to 100 mg/m^2/day after 2 cycles if no hematological toxicity is present. Patients are treated until progression or development of unacceptable toxicity.

Primary endpoint. The primary endpoint of the SPARC study is Progression-Free Survival (PFS). Progression is defined as first occurrence of tumor progression, a skeletal event, or symptomatic disease progression. Tumor progression is based on RECIST criteria for soft-tissue lesions or the occurrence of 2 or more new lesions on bone scan. A skeletal event includes a bone fracture, the need for bone surgery or radiation, or initiation of bisphosphonate therapy. Symptomatic progression is increase in patient-assessed PPI score, an increase in the consumption of analgesics, weight loss >= 10%, or a decline in ECOG performance status (Sternberg, BJU International, 96:990-994, 2005).

Secondary endpoints. Secondary endpoints include overall survival and time to pain progression.

- **We estimate that satraplatin could be a billion dollar franchise**

History. Satraplatin was originally developed for Bristol Myers Squibb (BMY:NYSE, Not Rated) by Johnson Matthey. Following a strategic re-alignment in 1999, BMS returned the drug to Johnson Matthey who out-licensed it to then NeoTherapeutics, now Spectrum Pharmaceuticals (SPPI:Nasdaq, Not Rated). In response to a cash-crisis that occurred following the failure of a Spectrum Alzheimer's trial, they out-licensed the drug to GPC Biotech in October 2002. GPC Biotech paid $2 million in license fees and agreed to pay a further $2 million upon the dosing of the first patient in a registrational trial, $0.9 million of which was in the purchase of equity in Spectrum Pharmaceuticals, the remainder in cash. Additional milestones total $18-40 million. GPC Biotech will also pay Spectrum an undisclosed low-teen royalty on top-line sales.

Unique properties of satraplatin. We believe the platinum-containing chemotherapies (1st generation – cisplatin; 2nd generation – carboplatin & oxaliplatin) have been among the most successful chemotherapy drugs developed. Currently cisplatin and carboplatin are off patent, and oxaliplatin (Eloxatin, Sanofi-Aventis, SNY:NYSE, Not Rated) is estimated to have worldwide sales of over $2.0 billion in 2005. All currently marketed platinum drugs are administered as I.V. infusions.

Satraplatin is an oral, 3rd generation platinum compound. The oral bioavailability of satraplatin may offer a unique advantage in using satraplatin in combination with radiation therapies. Platinum-containing chemotherapies have demonstrated the potential to synergize with radiation, however, the incompatibility in logistics of receiving I.V. platinum therapy and daily radiation has limited the utilization of this approach due to unacceptable toxicity and unfavorable paring of the pharmacokinetics of the therapies. The availability of an oral platinum chemotherapy such as satraplatin with a side effect profile permitting daily dosing to accompany radiation has the potential to allow for each dose of radiation to be administered close to peak circulating levels of the chemotherapy potentially leading to significantly improved outcomes. We note that 700,000 patients in the U.S. receive radiation therapy annually. Currently GPCB is sponsoring a Phase I/II study of satraplatin in combination with radiation in locally advanced NSCLC; we note that 170,000 lung cancer patients alone in the U.S. receive radiation treatment each year.

In addition, satraplatin has different tumor killing, resistance and safety profiles than other platinum analogs which can be exploited by GPCB for its development. Management chose 2nd line HRPC as the first indication to pursue for satraplatin, based on the thinking that there are no approved therapies in this setting, and that other platinum analogs have not played a significant role in this setting. In addition to the SPARC study, GPCB is currently conducting studies of satraplatin in 2nd line breast cancer, front line metastatic NSCLC with Taxol, locally advanced NSCLC in combination with radiation, and in advanced solid tumors in combination with Taxotere.

Satraplatin has a safety profile comparable to that of carboplatin, the best tolerated platinum analogs. Satraplatin does not have the renal toxicity, neurotoixicity or ototoxicity associated with cisplatin, or the neurotoxicity associated with oxaliplatin. The dose limiting toxicity of satraplatin is myelosuppression, primarily neutropenia and thrombocytopenia, which are dose-dependent and reversible. Satraplatin can also cause nausea and vomiting (Grade 3 and 4 in 13% patients), but it can be successfully managed by pre-medication with anti-emetic agents.

With the successes of Gleevec (Novartis, NVS:NYSE, *Not Rated*), Tarceva (OSI Pharmaceuticals, OSIP:Nasdaq, *Not Rated*), Revlimid (Celgene, CELG:Nasdaq, *Not Rated*) and others, we believe that the acceptance of oral cancer therapies are increasing in the U.S. and the reimbursement environment for these drugs will be more favorable.
We estimate that satraplatin could be developed into a billion dollar franchise.

IP. GPC Biotech believes that the combination of patent life and patent extension could provide protection of satraplatin through 2013 and potentially to 2015 in the U.S. The Company plans to extend the medical use patent (expires Sept 2010) rather than the composition of matter patent (expires Dec 2008) under Hatch-Waxman in the U.S., which in this case may be granted a 5-year extension. There is also data exclusivity protection for 10 years post approval in Europe.

- **Satraplatin in 10 Phase I, I/II and II studies**

Phase I/II study of satraplatin in combination with radiation in locally advanced NSCLC

The Company initiated a Phase I/II, open-label, uncontrolled, one center trial of satraplatin in combination with radiation in locally advanced NSCLC patients during Q3:04. This is one of the first exploratory studies probing for satraplatin's activity in a variety of oncological settings. The Phase I portion of the trial plans to enroll 30 NSCLC patients who have failed all prior therapies. The goal is to evaluate tolerability, safety, dose limiting toxicity and maximum tolerated dose of the combination regimen. This portion of the study is expected to takes 12-18 months to complete. The Phase II portion of the study also plans to enroll 30 patients, who have medically inoperable, locally advanced, Stage 2 or 3 NSCLC, are candidates for radiation therapy, and have had no prior radiation therapy to the primary tumor site and no cytotoxic chemotherapy. The efficacy endpoint for this portion of the study will be tumor response as measured by the RECIST criteria. This portion is also expected to takes 12-18 months to complete. To date, we believe that the potential for synergy between platinum-containing chemotherapy and radiation has not been optimally exploited due to treatment-limiting toxicities and the challenges associated with pairing the pharmacokinetics of chemotherapy with the delivery of radiation. We believe the opportunity to combine an oral platinum therapy having a favorable toxicity profile with radiation is significant, as there are 700,000 patients in the U.S. per year that receive radiation therapy.

Two Phase I studies of satraplatin in combination with Taxotere in advanced solid tumors

GPCB initiated 2 Phase I studies of satraplatin in combination with Taxotere in advanced solid tumors in July, 05 and Q1:06, respectively, with different dosing schedules of Taxotere (once a week or once every 3 weeks). The first Phase I Study is an open-label, single center study to be conducted at University of Wisconsin, Madison, and the target enrollment is 48. Main objectives include safety, toxicity, determination of maximum tolerated doses, and objective responses.

Phase II study of satraplatin single agent in metastatic breast cancer (will discontinue single agent study and focus on combination therapies)

The Company initiated a Phase II study of single agent satraplatin in metastatic breast cancer patients who received no more than one prior chemotherapy regimen, in November, 05. The open-label study plans to enroll 80 patients in the U.S. at 57 sites in the US Oncology network, and the primary endpoint is objective response rate. Patients who are platinum-refractory will be excluded; and the prior chemotherapy regimen includes anthracycline, taxanes or both. Patients will receive

satraplatin at 80 mg/m^2 each day from day 1-5 on a 21-day cycle. Dose could be escalated to 100 mg/m^2 after two cycles of treatment. The first evaluation will be performed after two cycles, and the maximum treatment period is one year. Her2 positive patients are allowed in the study and can receive Herceptin concurrently. The Study is expected to take 18-24 months to complete. The study results will form the basis for potential further studies in breast cancer including combination therapy of satraplatin with taxanes, Herceptin, or Xeloda.

Phase II study of satraplatin in combination with Taxol in NSCLC
GPCB initiated a Phase II study of satraplatin in combination with Taxol in front line unresectable advanced NSCLC in December, 2005. The Study is an open label study of 40 patients led by investigators at the Sarah Cannon Research Institute in Nashville, Tennessee. The primary endpoint is object response.

Two Phase I studies of satraplatin in combination with Xeloda in advanced solid tumors: first oral-oral combination
GPCB initiated 2 Phase I studies of satraplatin in combination with Xeloda in advanced solid tumors in May, 2006, one with concurrent administration of the two agents, the other sequential administration. This is the first oral-oral combination study initiated. The study is an open-label study of up to 24 patients. The primary endpoint is to assess maximally tolerated dose.

Phase II study of satraplatin in combination with Tarceva in front-line advanced NSCLC
GPCB initiated the Phase II, 20-center, 120-patients, randomized study in August, 06 evaluating the combination of satraplatin and Tarceva versus Tarceva alone in front line advanced NSCLC patients over 70 years old. The primary endpoint is progress-free survival. Secondary endpoints include overall survival, response rates, and safety.

This is the second oral-oral combination study GPCB initiated; the first one was the Phase I satraplatin-Xeloda combination studies in solid tumors. In addition, Tarceva and satraplatin are given in a sequential fashion in this study to maximize therapeutic effects. The sequential (but not the simultaneous) treatment of JM118 and Tarceva was shown to result in a synergistic effects in the H-460 non small cell lung cancer cells *in vitro*. The highest synergistic effect was observed when JM118 (24 h treatment) was followed by Tarceva (72 h treatment) (Schuhmacher et al., Abstract #A216, AACR-NCI-EORTC, November, 2005).

Phase I/II study of satraplatin and Xeloda in combination of radiation in rectal cancer
This study was initiated during Q3:06.

Phase I study of satraplatin in combination with Gemzar in advanced solid tumors
This study was initiated during Q3:06.

- **Potential upcoming milestones/events**

March 15	Q4:06 earnings report
Mid April	Notification from the FDA whether satraplatin NDA is accepted for filing
H1:07	Potential MAA submission for satraplatin in 2nd line hormone refractory prostate cancer (Pharmion, PHRM:Nasdaq, ***Buy***)
H1:07	Potential Phase I data for 1D09C3 in lymphoma
H1:07	Potential Phase I/II data for satraplatin in combination with radiation in locally advanced NSCLC
June 1	Potential ODAC panel to discuss satraplatin's approvability in 2nd line HRPC
June 1-6	ASCO presentations, Chicago, IL
Mid August	PDUFA for satraplatin's "accelerated approval" in 2nd line HRPC
Fall	Final analysis of overall survival of SPARC study

GPC Biotech
Ticker: (GPCB:Nasdaq)
2/26/2007

INCOME STATEMENT
euros in thousands, except per share data

	2004A	2005A	2006E					2007E	2008E	2009E	2010E
	FY:04A	FY:05A	Q1A	Q2A	Q3A	Q4	FY:06E	FY:07E	FY:08E	FY:09E	FY:10E
Revenues:											
Collaborative Revenue	12,703	9,341	5,398	5,425	6,480	6,480	23,783	17,825	6,000	16,000	0
Milestone Payments, Grants	0	0		194	86		280	24,667	0	0	0
Royalties	0	0					0	0	26,005	40,083	48,111
Product Revenue	0	0					0	5,683	61,126	124,653	182,592
Total Revenues	**€ 12,649**	**€ 9,341**	€ 5,398	€ 5,619	€ 6,566	€ 6,480	**€ 24,063**	**€ 48,175**	**€ 93,131**	**€ 180,736**	**€ 230,703**
Cost and Expenses:											
COGS								669	7,191	14,665	21,481
R&D	40,202	55,684	14,519	14,535	20,072	20,000	69,126	77,000	71,000	73,500	76,500
SG&A	13,173	17,790	4,377	5,800	6,070	6,500	22,747	33,000	50,000	52,000	56,000
Total Costs and Expenses	**€ 53,375**	**€ 73,474**	18,896	20,335	26,142	26,500	**€ 91,873**	**€ 110,669**	**€ 128,191**	**€ 140,165**	**€ 153,981**
Operating income (loss)	(40,726)	(64,133)	(13,498)	(14,716)	(19,576)	(20,020)	(67,810)	(62,493)	(35,060)	40,571	76,721
Net Interest Income (Expense)	2,519	2,860	929	1,063	1,063	663	3,718	2,147	0	0	0
Other Income (Expense)	(1,554)	2,938	(674)	(1,473)	(105)	(400)	(2,652)	0	0	0	0
Income Before Income Taxes	(39,761)	(58,335)	(13,243)	(15,126)	(18,618)	(19,757)	(66,744)	(60,346)	(35,060)	40,571	76,721
Provision for income taxes	0	0					0	0	0	15,823	29,921
Net Income	(39,761)	(58,335)	(13,243)	(15,126)	(18,618)	(19,757)	(66,744)	(60,346)	(35,060)	**24,748**	**46,800**
One-Time non-cash charges	0	3,705	(433)				(433)	0	0	0	0
Amortization of intangibles	166	195	72	71	70	71	284	0	0	0	0
EPS w/out 1 time charges	(1.59)	(1.95)	(0.42)	(0.46)	(0.56)	(0.59)	(2.04)	(1.77)	(0.99)	**0.69**	**1.30**
EPS GAAP	(1.60)	(2.08)	(0.41)	(0.46)	(0.56)	(0.60)	(2.03)	(1.77)	(0.99)	**0.69**	**1.30**
weighted shares outstanding	24,951	29,877	31,317	33,103	33,208	33,283	32,728	34,057	35,335	35,635	35,935

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GPC Biotech Clinical Development Timelines

Drug	**Satraplatin (oral platinum)**									**1D09C3** (human mAb)	**TBD** (cell cycle inhibitor)
Indication	*2nd line HRPC (SPARC Trial)*	*2nd line metastatic breast cancer*	*Front line NSCLC in combination with Taxol*	*Front line in inoperable advanced NSCLC (over age 70), in combination with Tarceva*	*Locally advanced NSCLC in combination with radiation*	*Combo w/TAXOTERE in cancers*	*Combo with Xeloda (oral) in advanced solid tumors*	*Combo with Gemzar in advanced solid tumors*	*Combo with radiation and Xeloda in rectal cancer*	*Refractory B-cell lymphomas & combo therapy w/Rituxan*	*Refractory Cancers*
Partner	*Pharmion (Europe, Turkey, Middle East, Australia, New Zealand)*									--	--
Q3:03	Commence Phase III trial √										
Q4:03											
Q1:04											
Q2:04											
Q3:04					Initiate Phase I √						
Q4:04											
Q1:05										Initiate Phase I √	
Q2:05											
Q3:05						Initiate Phase I √					
Q4:05	Complete Phase III enrollment √	Initiate Phase II √	Initiate Phase II √								
Q1:06						Initiate second Phase I with different dosing √					Complete pre-clinical development work
Q2:06	Interim analysis √						Initiate Phase I √				
Q3:06	Phase III PFS data √			Initiate Phase II √		Phase I/II data		Initiate Phase I √	Initiate Phase I/II √		
Q4:06										Partial data at ASH	
Q1:07	NDA filing √									Phase I data	
Q2:07	Potential accelerated approval and launch	Phase II data	Phase II data		Phase I data						
Q3:07	Potential accelerated approval and launch; Phase III overall survival data; Potential final approval										Potential IND filing
Q4:07				Phase II data			Phase I data	Phase I data	Phase I/II data		
H1:08											
H2:08											
H1:09											
H2:09											

Source: GPC Biotech and Pacific Growth Equities estimates
√ = achieved

Appendix A
Required Disclosures

26-Feb-2007 08:52:37 AM

Disclosures for GPC Biotech AG (GPCB)

Pacific Growth Equities, LLC was making a market in the securities of GPC Biotech AG (GPCB) at the time of this report.

Disclosures for Pharmion Corp (PHRM)

Pacific Growth Equities, LLC was making a market in the securities of Pharmion Corp (PHRM) at the time of this report.

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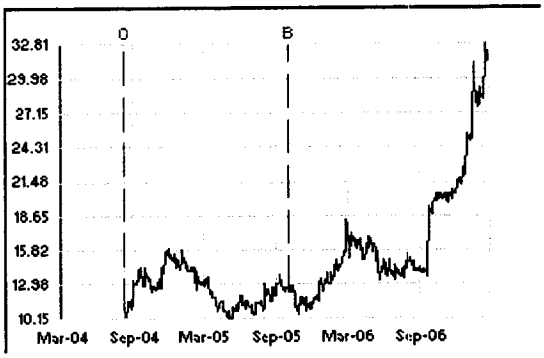
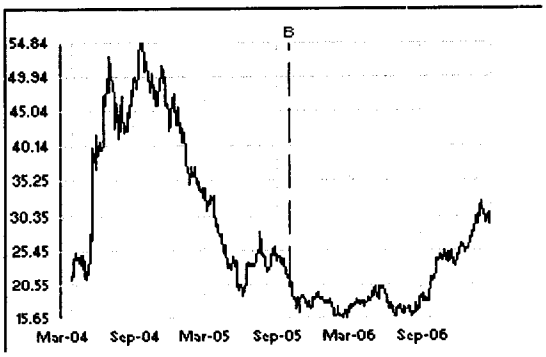
GPCB - GPC Biotech AG - 23-Feb-2007		
Date	**Price**	**Rating**
8/9/2004	10.80	O
10/3/2005	12.64	B

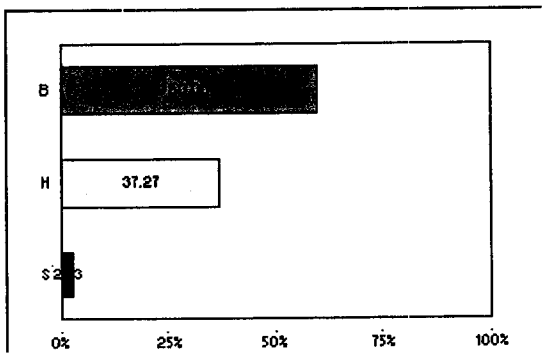


PHRM - Pharmion Corp - 23-Feb-2007		
Date	**Price**	**Rating**
10/3/2005	21.33	B

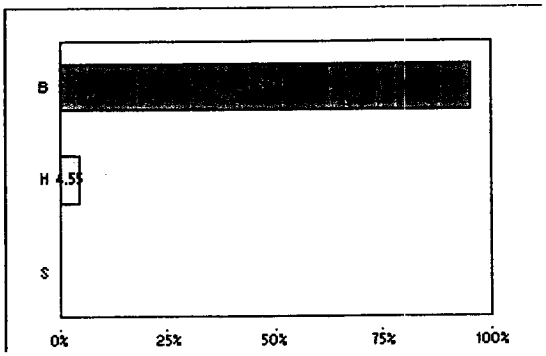


Research Ratings Distribution

Ratings - All - 23-Feb-2007		
Rating	Qty	Pct
B	66	60.00
H	41	37.27
S	3	2.73



Ratings - Transactions in the Last 12 Months - 23-Feb-2007		
Rating	Qty	Pct
B	21	95.45
H	1	4.55
S	0	0.00



Ratings Definitions - Current (Effective 01-Oct-2005)		
B	Buy	20%+ Upside over 12 months
N	Neutral	Perform in-line with market and/or limited opinion
S	Sell	20%+ downside next 12 months

Ratings Definitions - Legacy		
O	Over Weight	The stock's total return is expected to exceed the average total return of the analyst's industry (or industry team's) coverage universe, on a risk-adjusted basis, over the next 12-18 months.
E	Equal Weight	The stock's total return is expected to be in line with the average total return of the analyst's industry (or industry team's) coverage universe, on a risk-adjusted basis, over the next 12-18 months.
U	Under Weight	The stock's total return is expected to be below the average total return of the analyst's industry (or the industry team's) coverage universe, on a risk-adjusted basis, over the next 12-18 months.

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